

# **Chapter 10**

## **Professional and Technical Services**



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## **GENERAL INFORMATION**

Within limitations, AHCCCS covers medically necessary medical and surgical services performed in offices, clinics, hospitals, homes, or other locations by licensed physicians, dentists, and mid-level practitioners.

Cosmetic surgery, experimental procedures, and unproven procedures are not covered.

Physicians and mid-level practitioners must bill for services on the CMS 1500 claim form. Services must be billed using appropriate CPT and HCPCS codes and procedure modifiers, if applicable. Dentists must bill for services on the ADA 2002 form using CDT-4 codes. The range of procedure codes that may be used by each provider type is listed in the provider type profile maintained by AHCCCS Provider Registration Department.

Providers should contact the Claims Customer Service Unit to determine if a procedure is covered by AHCCCS or if a specific code can be billed on a fee-for-service claim.

Phoenix area: (602) 417-7670 (Option 4)

All others: 1-800-794-6862 (In state)

1-800-523-0231, Ext. 7670 (Out of state)

## **CORRECT CODING INITIATIVE**

AHCCCS follows Medicare's Correct Coding Initiative (CCI) policy and performs CCI edits and audits on fee-for-service claims for the same provider, same recipient, and same date of service.

Correct coding means billing for procedures with the appropriate comprehensive code. "Unbundling" is the billing of multiple procedure codes for services that are covered by a single comprehensive code.

Some examples of **incorrect** coding include:

- ☒ Fragmenting one service into components and coding each as if it were a separate service.
- ☒ Billing separate codes for related services when one code includes all related services.
- ☒ Breaking out bilateral procedures when one code is appropriate.
- ☒ Downcoding a service in order to use an additional code when one higher level, more comprehensive code is appropriate.

## CORRECT CODING INITIATIVE (CONT.)

All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- ☒ Represent the standard of care for the overall procedure, or
- ☒ Are necessary to accomplish the comprehensive procedure, or
- ☒ Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

Modifier 59 may be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 - 77499).

If no code exists that identifies a bilateral service as bilateral, the provider may bill the code twice with modifier 50 on the second code. Separate services during the post-operative period may be billed with modifier 58 or 78. Other modifiers may be appropriately attached to comprehensive codes (e.g., professional component (26), assistant surgeon (80), etc.).

CCI edits and audits are run on a prepayment basis. The CCI edit results are:

- L140.1 - Invalid Coding Combination; Mutually Exclusive Code Paid (Deny)
- L140.2 - Invalid Coding Combination; Component Previously Paid (Deny)
- L140.3 - Invalid Coding Combination; Comprehensive Previously Paid (Deny)
- L140.4 - Invalid Coding Combination; Multiple Component Codes (Approve. Post payment review and possible recoupment)
- L140.5 – Invalid Coding Combination; Ventilator Management with E/M Code (Deny)
- L140.6 - Invalid Coding Combination; Discharge Management with E/M Code (Deny)

To meet CCI requirements, billers should follow these steps:

1. Determine if the code to be billed is a mutually exclusive code.

Mutually exclusive procedures are those that cannot reasonably be performed in the same session (e.g., codes for “initial” and “subsequent” services).

If a mutually exclusive code and its “partner” are billed on the same claim, the system will allow the code with the lowest capped fee. If the “partner” code has been paid, the system will deny the billed code.



## **CORRECT CODING INITIATIVE (CONT.)**

To meet CCI requirements, billers should follow these steps (Cont.):

2. Determine if the code to be billed is a component of a comprehensive code that also will be billed or that has been billed.

The comprehensive code must be billed, if applicable. Claims for component codes that describe services distinct or separate from the services described by the comprehensive code may be reimbursed when billed with one of the following modifiers, if appropriate:

24, 25, 50, 57, 58, 59, 78, E1-E4, F1-F9, FA, LC, LD, RC, T1-T9, TA, RT, or LT.

3. Determine if the code to be billed is a comprehensive code.

If it is a comprehensive code and one of its components has been billed and paid, that claim for the component code must be voided before the comprehensive code can be billed.

Component codes cannot be billed if the comprehensive code is the most appropriate code.

## PROFESSIONAL AND TECHNICAL SERVICES

**NOTE:** The covered services, limitations, and exclusions described on the following pages are global in nature and are listed here to offer general guidance to providers. Specific questions regarding covered services, limitations, and exclusions should be addressed to the AHCCCS Office of Special Programs at (602) 417-4053. The *AHCCCS Medical Policy Manual (AMPM)* also is available on the AHCCCS web site at [www.azahcccs.gov](http://www.azahcccs.gov).

### Abortion

- ☒ AHCCCS does not cover abortion counseling and abortions, unless:
  - ✓ The pregnant member suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated, or
  - ✓ The pregnancy is a result of rape or incest, or
  - ✓ The pregnancy termination is medically necessary according to the medical judgment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member by:
    - ☒ Creating a serious physical or mental health problem for the pregnant member, or
    - ☒ Seriously impairing a bodily function of the pregnant member, or
    - ☒ Causing dysfunction of a bodily organ or part of the pregnant member, or
    - ☒ Exacerbating a health problem of the pregnant member, or
    - ☒ Preventing the pregnant member from obtaining treatment for a health problem.
- ☒ All medically necessary abortions require prior authorization (PA) except in cases of medical emergency.
  - ✓ In the event of a medical emergency, all documentation of medical necessity must accompany the claim when submitted for reimbursement.
- ☒ The request for PA must be accompanied by a completed Certificate of Medical Necessity for Pregnancy Termination (See the *AHCCCS Medical Policy Manual (AMPM)*, Exhibit 410-1).
  - ✓ If the pregnancy is a result of rape or incest and the recipient is under 18 years of age, a parent or legal guardian must sign the Certificate of Necessity.
- ☒ The AHCCCS PA Unit will review the request and the certification and may authorize the procedure if medically necessary.



## **PROFESSIONAL AND TECHNICAL SERVICES (CONT.)**

### **Anesthesia services for Date of Service PRIOR to 7/01/2005**

- ☒ Anesthesia services (except epidurals) require the *continuous physical presence* of the anesthesiologist or certified registered nurse anesthetist (CRNA).
- ☒ Anesthesiologists and CRNAs must enter the appropriate American Society of Anesthesiologists (ASA) code (five-digit CPT procedure codes 00100 - 01999) in Field 24D and the total number of time units in Field 24G of the CMS 1500 claim form.
  - ✓ One unit is a time increment of 15 minutes or any portion thereof.
- ☒ The begin and end time of the anesthesia administration must be entered on the claim on the line following the ASA code.
  - ✓ The number of units billed must not exceed the period of time expressed by the begin and end time entered on the claim.
- ☒ AHCCCS uses the limits and guidelines as established by ASA for base and time units for most anesthesia procedures.
  - ✓ If the units billed exceed the maximum allowed for the procedure, the AHCCCS Claims System will pend the claim for medical review.
- ☒ The AHCCCS system adds the base units for the ASA code to the number of units billed and multiplies the total by the Fee-For-Service rate.
- ☒ Billing for labor and delivery
  - ✓ Providers should bill ASA code 01967 (Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)) for labor and delivery when epidural anesthesia is used.
    - ☒ Providers may bill for a maximum of 8 units (two hours).
  - ✓ If labor results in a Cesarean section, add-on code +01968 (Cesarean delivery following neuraxial labor analgesia/anesthesia) should be added.
    - ☒ Providers should bill properly for the time of the Cesarean section portion of the service.
  - ✓ A base of 5 units is added for ASA code 01967, and a base of 3 units is added for +01968.
  - ✓ For all other labor and delivery, ASA codes 01960 (Anesthesia for vaginal delivery only) and code 01961 (Anesthesia for Cesarean delivery only) should be used.

## PROFESSIONAL AND TECHNICAL SERVICES (CONT.)

### Anesthesia services (Cont.)

- ☒ Providers who bill other CPT codes for additional procedures performed during anesthesia administration must use the units field to indicate the number of times the procedure was performed.

- ✓ Providers should not include the Basic Unit Value listed in the ASA Manual as part of the units billed.

#### Example:

A provider who bills 36556 (Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older) should bill one unit.

Billing the Basic Unit Value of four would indicate placement of four catheters.

- ✓ Reimbursement for these services is based on the capped fee schedule.
- ☒ The following anesthesia services are not covered:
  - ✓ 00938 (Insertion of penile prosthesis)
  - ✓ 99100, 99116, 99135, and 99140 (Qualifying circumstances)
  - ✓ Physical status
- ☒ AHCCCS will reimburse only one provider for anesthesia administration
  - ✓ When a CRNA administers the anesthesia, AHCCCS will not reimburse the anesthesiologist for oversight services.
    - ☒ Only the CRNA will be reimbursed by AHCCCS.
  - ✓ When one provider begins the anesthesia administration and another provider takes over, only the first provider may bill for the service.
    - ☒ If both providers bill for the service, one claim will be denied as a near duplicate.
- ☒ **Anesthesia Services for Dates of Service 7/01/2005 and after**
  - ✓ Anesthesia services (except epidurals) require the *continuous physical presence* of the anesthesiologist or certified registered nurse anesthetist (CRNA).
- ☒ Anesthesiologists and CRNAs must enter the appropriate American Society of Anesthesiologists (ASA) code (five-digit CPT procedure codes 00100 - 01999) in Field 24D and the total number of MINUTES in Field 24G of the CMS 1500 claim form.



- ☑ The begin and end time of the anesthesia administration must be entered on the claim on the line following the ASA code.
  - ✓ The number of minutes billed must not exceed the period of time expressed by the begin and end time entered on the claim.
- ☑ AHCCCS uses the limits and guidelines as established by ASA for base and time units (AHCCCS system will calculate units based on minutes billed) for most anesthesia procedures.
- ☑ The AHCCCS system adds the base units for the ASA code to the number of base units (calculated from minutes billed) and multiplies the total by the established Fee For Service Rate to obtain the allowed amount.
- ☑ **Billing for labor and delivery**
  - ✓ Providers should bill ASA code 01967 (Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes the repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)) for labor and delivery when epidural is used.
  - ✓ Providers may bill for a maximum of 180 minutes (three hours).
  - ✓ If labor results in a Cesarean section, add-on code +01968 (Cesarean delivery following neuraxial labor analgesia/anesthesia) should be added.
  - ✓ Providers should bill for the time of the Cesarean section portion of the service only.
  - ✓ A base of 5 units is added for the ASA code 01967, and a base of 3 units is added for +01968.
  - ✓ For all other labor and delivery, ASA codes 01960 (Anesthesia for vaginal delivery only) and code 01961 (Anesthesia for Cesarean delivery only) should be used.
  - ✓ Providers who bill other CPT codes for additional procedures performed during anesthesia administration must use the units field to indicate the number of times the procedure was performed.
  - ✓ Providers should not include the Basic Unit Value listed in the ASA Manual as part of the units billed.

Example:

A provider who bills 36556 (Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older) should bill one unit.

Billing the Basic Unit Value of four would indicate placement of four catheters.

- ✓ Reimbursement is based on capped fee schedule.

☒ **The following anesthesia service are not covered:**

- ✓ 00938 (Insertion of penile prosthesis) 99100, 99116, 99135 and 99140 (Qualifying circumstances) Physical status.

- ☒ AHCCCS will reimburse only one provider for anesthesia administration when a CRNA administers the anesthesia, AHCCCS will not reimburse the anesthesiologist for oversight services. Only the CRNA will be reimbursed by AHCCCS when one provider begins the anesthesia administration and another provider takes over, only the first provider may bill for the service. If both providers bill for the service, one claim will be denied as a near duplicate.

## Dental services

- ☒ Within limitations, AHCCCS covers dental services provided by a licensed dentist or dental hygienist for Acute Care recipients. **Effective 10/1/2007**, ALTCS recipients age 21 and older may receive medically necessary dental services up to \$1,000.00 per recipient per contract year.

NOTE: Because emergency dental services are a separately identified covered service for all recipients, these services are excluded from the ALTCS Adult Dental Benefit.

- ☒ Covered EMERGENCY dental services include:

- ✓ Emergency oral examination
- ✓ Radiographs limited to use as a diagnostic tool
- ✓ Composite resin involving incisal angle due to recent tooth fracture



## **PROFESSIONAL AND TECHNICAL SERVICES (CONT.)**

### **Dental services (Cont.)**

- ☒ Covered emergency dental services include (Cont.):
  - ✓ Prefabricated crowns to eliminate pain due to recent tooth fracture
  - ✓ Recementation of inlays and crowns
  - ✓ Pulp cap-direct plus protective filling
  - ✓ Vital pulpotomy
  - ✓ Apicoectomy performed as separate procedure on anterior teeth for treatment of acute infection or to eliminate pain
  - ✓ Treatment for acute necrotizing ulcerative gingivitis
  - ✓ Recementation of bridge work
  - ✓ Extractions
  - ✓ Tooth reimplantation in original socket after avulsion due to trauma
  - ✓ Incision and drainage of abscess
  - ✓ Treatment of fractures
  - ✓ Appropriate anesthesia for patient management
  - ✓ Temporary restoration which provides palliative/sedative care (limited to the tooth receiving emergency treatment)
  - ✓ Root canals, limited to six anterior teeth (upper and lower) as treatment for acute infection or to eliminate pain.
- ☒ Medically necessary dentures and pre-transplant dental services within limitations.
- ☒ Covered EPSDT dental services for recipients under age 21 and KidsCare recipients include:
  - ✓ Screening and preventive services specified in periodicity schedule
  - ✓ Emergency dental services described above
  - ✓ All medically necessary therapeutic dental services

## PROFESSIONAL AND TECHNICAL SERVICES (CONT.)

### Dental services (Cont.)

- ☒ Dental coverage limitations
  - ✓ Extractions are limited to emergency care.
  - ✓ Routine restorative procedures and routine root canal therapy are not considered emergency services.
  - ✓ Treatment for prevention of pulpal death and imminent tooth loss is limited to non-cast fillings, preformed stainless steel crowns, pulp caps and pulpotomies only for tooth causing pain or in presence of active infection.
  - ✓ Maxillofacial dental services provided by a dentist are not covered except to the extent prescribed for reduction of trauma, including reconstruction of regions of the maxilla and/or the mandible.
  - ✓ Diagnosis and treatment of temporomandibular joint dysfunction is not covered except for reduction of trauma.
- ☒ Prior authorization requirements
  - ✓ PA is not required for emergency dental services for all recipients nor for preventive/therapeutic dental services for EPSDT and KidsCare recipients.
  - ✓ Dental surgery services for EPSDT and KidsCare recipients require PA.
  - ✓ Provision or replacement, repairs, or adjustment of dentures and provision of obturators and other prosthetic appliances for restoration or rehabilitation provided to adults require PA.
  - ✓ Pre-transplant dental services that are medically necessary in order for the recipient to receive the major organ or tissue transplant require prior authorization from the AHCCCS transplant case manager.
- ☒ Billing requirements
  - ✓ Dentists must bill on the ADA 2002 claim form using CDT-4 codes.
  - ✓ Only oral surgeons registered as Provider Type 07 (Dentists) may use CPT Evaluation and Management (E/M) codes on the CMS 1500 claim form to bill AHCCCS for office visits.



## **PROFESSIONAL AND TECHNICAL SERVICES (CONT.)**

### **Dental services (Cont.)**

- ☒ Billing requirements (cont.)
  - ✓ Dentists who are not oral surgeons must use one of the following codes to bill for office visits and evaluation services:
    - D0120 - Periodic oral exam
    - D0140 - Limited oral evaluation -- problem focused
    - D0150 - Comprehensive oral evaluation
    - D0160 - Detailed and extensive oral exam -- problem focused
    - D9430 - Office visit for observation (during regularly scheduled hours) – no other services performed
    - D9440 - Office visit -- after regularly scheduled hours
  - ✓ Dentists may use appropriate E/M codes for hospital consultation, emergency room services, and hospital visits.

### **Discharge management**

- ☒ Physicians and mid-level practitioners who bill Evaluation and Management (E/M) codes 99238 and 99239 for discharge management should not bill any other evaluation and management code for the same date when submitting claims to AHCCCS.
- ☒ The E/M codes for hospital discharge day management are used to report all services provided on the date of discharge, including final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records.
- ☒ If a provider submits a claim for discharge management and another E/M code for the same date, the E/M code will be paid, but the discharge management code will be denied.

### **EPSDT services**

- ☒ AHCCCS covers comprehensive health care for recipients under age 21 through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.
- ☒ EPSDT also covers all medically necessary services to treat or ameliorate physical and behavioral health disorders, a defect, or a condition identified in an EPSDT screening.
- ☒ KidsCare (Title XXI) recipients are eligible for nearly the same services as EPSDT recipients eligible under Title XIX.
  - ✓ KidsCare recipients are not eligible for licensed midwife services and home births.

## PROFESSIONAL AND TECHNICAL SERVICES (CONT.)

### EPSDT services (Cont.)

- ☒ EPSDT screening services should be provided in compliance with AHCCCS medical policy including the periodicity schedule which meets reasonable standards of medical practice and specified screening services at each stage of a child's life.
- ☒ The EPSDT screening requirements are:
  - ✓ Comprehensive health, nutritional and developmental history
  - ✓ Comprehensive unclothed physical examination
  - ✓ Screening for immunizations appropriate to age and health history.
  - ✓ Laboratory tests
  - ✓ Health education
  - ✓ Vision, speech and hearing assessment
  - ✓ Age appropriate dental screening
  - ✓ Behavioral health services
- ☒ Under the federal Vaccines for Children (VFC) program, providers are paid a capped fee for administration of vaccines to recipients 18 and younger.
  - ✓ Providers must bill the appropriate CPT code for the immunization with the "SL" (State supplied vaccine) modifier that identifies the immunization as part of the VFC program.
  - ✓ Providers must *not* use the immunization administration CPT codes 90471, 90472, 90473, and 90474 when billing under the VFC program.
  - ✓ Because the vaccine is made available to providers free of charge, they must not bill for the vaccine itself.
  - ✓ Vaccines covered under the VFC program:
    - 90633 Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule
    - 90634 Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule
    - 90645 Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule)
    - 90646 Hemophilus influenza b vaccine (Hib), PRP-D conjugate, for booster use only
    - 90647 Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule)
    - 90648 Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule)



## **PROFESSIONAL AND TECHNICAL SERVICES (CONT.)**

### **EPSDT services (Cont.)**

✓ Vaccines covered under the VFC program (Cont.):

- 90655 Influenza virus vaccine, split virus, preservative free, 6-35 months dosage (covered under VFC only for high-risk children)
- 90657 Influenza virus vaccine, split virus, 6-35 months dosage (covered under VFC only for high-risk children)
- 90658 Influenza virus vaccine, split virus, 3 years and above (covered under VFC only for high-risk children)
- 90669 Pneumococcal conjugate vaccine, polyvalent, for children under 5 years
- 90698 Diphtheria, tetanus toxoids, acellular pertussis vaccine, hemophilus influenza b, and poliovirus vaccine, inactivated (DtaP-Hib-IPV), for intramuscular use
- 90700 Diphtheria, tetanus toxoids, and acellular pertussis (DTaP)
- 90701 Diphtheria, tetanus toxoids, and whole cell pertussis vaccine (DTP)
- 90702 Diphtheria and tetanus toxoids (DT) adsorbed
- 90707 Measles, mumps and rubella virus vaccine (MMR)
- 90713 Poliovirus vaccine, inactivated (IPV)
- 90716 Varicella virus vaccine, live
- 90718 Tetanus and diphtheria toxoids (Td)
- 90720 Diphtheria, tetanus toxoids and whole cell pertussis vaccine and hemophilus influenza b vaccine (DTP-Hib)
- 90721 Diphtheria, tetanus toxoids, and acellular pertussis vaccine and hemophilus influenza b vaccine (DtaP-Hib)
- 90723 Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV)
- 90732 Pneumococcal polysaccharide, 23 valent
- 90740 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule)
- 90743 Hepatitis B vaccine, adolescent (2 dose schedule)
- 90744 Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule)

## PROFESSIONAL AND TECHNICAL SERVICES (CONT.)

### EPSDT services (Cont.)

- ✓ Vaccines covered under the VFC program (Cont.):

90747 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule)

90748 Hepatitis B and hemophilus influenza b (HepB-Hib)

### Family planning services

- ☒ Family planning services are provided to eligible recipients who voluntarily choose to delay or prevent pregnancy and include covered medical, surgical, pharmacological and laboratory benefits.
- ☒ Family planning services include the provision of accurate information and counseling to allow eligible recipients to make informed decisions about the specific family planning methods available.
- ☒ Covered services include:
  - ✓ Contraceptive counseling, medications, supplies and associated medical and laboratory examinations, including, but not limited to, oral and injectable contraceptives, intrauterine devices, diaphragms, condoms, foams, and suppositories
  - ✓ Voluntary sterilization (male and female)
  - ✓ Natural family planning education or referral to qualified health professionals
- ☒ Limitations and exclusions:
  - ✓ Services for the diagnosis or treatment of infertility are not covered.
  - ✓ Abortion counseling is not covered.
  - ✓ Abortions are not covered, unless the abortion is essential to protect the life of the mother or when the pregnancy is the result of rape or incest. (See Page 10-4):
  - ✓ Sterilization services are not covered for Emergency Services Program (ESP) recipients, and claims for sterilization services for ESP recipients will be denied.
    - ☒ Providers should bill AHCCCS for delivery only charges for ESP recipients. (See Chapter 18, Emergency Services Program)
- ☒ AHCCCS requires a completed Federal Consent Form to be submitted with claims for all voluntary sterilization procedures.



## **PROFESSIONAL AND TECHNICAL SERVICES (CONT.)**

### **Family planning services (Cont.)**

- ☒ Federal consent requirements for voluntary sterilization require:
  - ✓ The recipient to be at least 21 years of age at the time consent is signed.
  - ✓ The recipient to be mentally competent.
  - ✓ Consent to be voluntary and obtained without duress.
  - ✓ Thirty days, but not more than 180 days, to have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery.
  - ✓ At least 72 hours to have passed since the recipient gave informed consent for the sterilization if the recipient is to be sterilized at the time of a premature delivery or emergency abdominal surgery.
  - ✓ The informed consent to have been given at least 30 days before the *expected* date of delivery in the case of premature delivery.
  - ✓ The person securing the informed consent and the physician performing the sterilization procedure to sign and date the consent form.
  - ✓ A copy of the signed Federal Consent Form to be submitted by each provider involved with the hospitalization and/or the sterilization procedure.
  - ✓ That sterilization consents may not be obtained when an eligible recipient:
    - ☒ Is in labor or childbirth.
    - ☒ Is seeking to obtain or obtaining an abortion.
    - ☒ Is under the influence of alcohol or other substances that affect that recipient's state of awareness.
- ☒ Providers must bill for IUDs on the CMS 1500 claim form using the following codes:
  - J7300 Intrauterine copper contraceptive (Paraguard)
  - J7302 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg (Mirena)
  - S4989 Contraceptive intrauterine device (e.g. progestacert IUD), including implants and supplies

## PROFESSIONAL AND TECHNICAL SERVICES (CONT.)

### Family planning services (Cont.)

- ☑ Providers must bill for Depo-provera injections on the CMS 1500 claim form using HCPCS code J1055 - Depo-provera (150mg)
- ☑ Norplant insertion is no longer an AHCCCS-covered service because the manufacturer, Wyeth, is no longer distributing Norplant in the United States.
  - ✓ Providers must not bill the AHCCCS Administration for CPT codes 11975 - Insertion, implantable contraceptive capsules and 11977 - Removal with reinsertion, implantable contraceptive capsules.

### Health risk assessment and screening tests

- ☑ AHCCCS covers health risk assessment and screening tests provided by a physician or other licensed practitioner for adult recipients and for EPSDT and KidsCare recipients.
- ☑ Services include clinical health risk assessments and screening tests, immunizations, and health education as appropriate for age, history, and health status.
- ☑ Prior authorization is not required for medically necessary health risk assessment and screening services performed by fee-for-service providers.
- ☑ Covered services include the following preventive health risk assessment and screening test services for non-hospitalized adults:
  - ✓ Hypertension screening (annually)
  - ✓ Cholesterol screening (once; additional tests based on history)
  - ✓ Mammography (annually after age 50; recommended annually for younger females who are at high risk due to immediate family history)
  - ✓ Cervical cytology (annually for a sexually active woman; after three successive normal exams the test may be less frequent)
  - ✓ Colon cancer screening (digital rectal exam and stool blood test, annually after age 50)
  - ✓ Sexually transmitted disease screening (at least once during pregnancy; other, based on history)
  - ✓ Tuberculosis screening (once; additional testing based on history)
  - ✓ HIV-screening
  - ✓ Immunizations
  - ✓ Prostate screening (annually after age 50; recommended annually for males 40 and older who are at high risk due to immediate family history)



## **PROFESSIONAL AND TECHNICAL SERVICES (CONT.)**

### **Health risk assessment and screening tests (Cont.)**

- ☒ Covered health risk assessment and screening test services for non-hospitalized adults (Cont.):
  - ✓ Physical examination and laboratory tests (as appropriate for recipient's medical necessity and professional practice guidelines)
- ☒ Physical examinations performed to satisfy the demands of outside public or private agencies such as the following are not covered services:
  - ✓ Qualification for insurance
  - ✓ Pre-employment physical examination
  - ✓ Qualification for sports or physical exercise activities (does not apply to EPSDT recipients)
  - ✓ Pilots examinations (FAA)
  - ✓ Disability certification to establish any kind of periodic payments
  - ✓ Evaluation for establishing third party liability
- ☒ Screening services provided more frequently than these professionally recommended guidelines will not be covered unless medically necessary.
- ☒ Reporting HIV infection
  - ✓ ICD-9 diagnosis code 042 (Human immunodeficiency virus [HIV] disease) should be used to report AIDS, AIDS-like syndrome, AIDS-related complex, or symptomatic HIV infection.
    - ☒ When using code 042, an additional code should be used to identify each manifestation of the infection.
    - ☒ If the manifestation is the reason for treatment, the code describing it should be listed first on the claim form.
    - ☒ Code 042 should not be used if there are no manifestations of the infection.
  - ✓ ICD-9 diagnosis code V08 (Asymptomatic human immunodeficiency virus [HIV] infection status) should be used to report that a patient tested positive but has no symptoms.
  - ✓ ICD-9 diagnosis code 795.71 (nonspecific serologic evidence of HIV) should be used when results of an HIV test are inconclusive.
  - ✓ ICD-9 diagnosis code V01.7 (Contact with or exposure to communicable diseases, other viral diseases) should be used to report exposure to HIV.

## PROFESSIONAL AND TECHNICAL SERVICES (CONT.)

### Hysterectomy services

- ☒ AHCCCS covers medically necessary hysterectomy services.
- ☒ AHCCCS does not cover a hysterectomy service if it is performed solely to render the individual permanently incapable of reproducing.
- ☒ Coverage of hysterectomy services is limited to those cases in which medical necessity has been established by careful diagnosis, and, except for treatment of carcinoma and management of life-threatening hemorrhage, has been preceded by a trial of therapy (medical or surgical) which was proven unsatisfactory.
- ☒ Hysterectomy services may be considered medically necessary without a trial of therapy in the following cases:
  - ✓ Invasive carcinoma of the cervix
  - ✓ Ovarian carcinoma
  - ✓ Endometrial carcinoma
  - ✓ Carcinoma of the fallopian tube
  - ✓ Malignant gestational trophoblastic disease
  - ✓ Life-threatening uterine hemorrhage, uncontrolled by conservative therapy
  - ✓ Potentially life-threatening hemorrhage as in cervical pregnancy, interstitial pregnancy, or placenta abruptio
- ☒ Hysterectomy services require prior authorization.
  - ✓ In a life-threatening emergency, PA is not required, but the physician must certify in writing that an emergency existed.
- ☒ All claims for hysterectomy services are subject to medical review.
- ☒ A hysterectomy consent form (See Exhibit 10-1) or a hospital consent form that contains the same information as the hysterectomy consent form must be submitted with the claim.
  - ✓ The form must state that the patient will be permanently incapable of having children.
  - ✓ The form must be signed by the recipient, the physician who performs the hysterectomy, the person who obtains the recipient's consent and, if applicable, an interpreter.



## **PROFESSIONAL AND TECHNICAL SERVICES (CONT.)**

### **Licensed midwife services**

- ☒ A licensed midwife is an individual licensed by the Arizona Department of Health Services to provide maternity care pursuant to ARS §36-751 and AAC Title 9, Chapter 16, Article 1.
  - ✓ This provider type does not include certified nurse midwives licensed by the Arizona Board of Nursing as nurse practitioners or physician assistants licensed by the Arizona Board of Medical Examiners.
- ☒ Labor and delivery services provided by licensed midwives generally are provided in the recipient's home.
  - ✓ Licensed midwife services cannot be provided to AHCCCS recipients in a hospital, free-standing birthing center, or other licensed health care institution.
- ☒ Licensed midwives must obtain prior authorization from the AHCCCS Prior Authorization Unit.
  - ✓ Documentation certifying risk status of the recipient's pregnancy must be submitted to the PA Unit prior to providing licensed midwife services.
- ☒ Licensed midwife services may be provided only to pregnant AHCCCS recipients for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated.
  - ✓ The age of the recipient must be a consideration in the risk status evaluation.
  - ✓ Risk status must be determined at the time of the first visit and each trimester thereafter.
  - ✓ Recipients initially determined to have a high-risk pregnancy or recipients whose physical condition changes to high risk during the course of the pregnancy must immediately be referred to an AHCCCS-registered physician or practitioner.
- ☒ Upon delivery of the newborn, the licensed midwife is responsible for conducting the newborn examination and for referring the mother and newborn to a physician for follow-up care of any assessed problematic conditions.
- ☒ The licensed midwife also must notify the AHCCCS Administration's Newborn Reporting Line no later than three days after the birth in order to enroll the newborn with a health plan.
- ☒ Licensed midwives must bill on the CMS 1500 claim form
  - ✓ Licensed midwives must bill for delivery using CPT-4 code 59400 -- Routine obstetrical care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care.
  - ✓ Reimbursement is the lesser of billed charges or the AHCCCS capped fee.
    - ☒ Prenatal and postpartum care are bundled into one service, and all services related to the care of the pregnant woman are included in this reimbursement rate.



## PROFESSIONAL AND TECHNICAL SERVICES (CONT.)

### Licensed midwife services (Cont.)

- ☒ Licensed midwives must bill on the CMS 1500 claim form (Cont.)
  - ✓ If complications arise during the pregnancy and the woman must be referred to a physician, the licensed midwife may bill for prenatal care only using CPT code 99212 -- Office or other outpatient visit for the evaluation and management of an established patient..
  - ☒ Each visit should be billed on a separate line.

### Obstetrical services

- ☒ Information about obstetrical visits and services normally provided in uncomplicated maternity cases (and included in AHCCCS' reimbursement for the global CPT codes) can be found in the current issue of the *Physician's Current Procedural Terminology* (CPT) code book.
  - ✓ The CPT code book also provides information on the circumstances under which it is appropriate to bill separately for services not included in the global CPT codes, such as additional services required by medical complications of pregnancy.
- ☒ The global obstetrical (OB) package includes **all** OB visits prior to the delivery, the delivery, postpartum visits, and all services associated with admission to and discharge from a hospital.
  - ✓ Only services not included in the global OB care CPT code may be billed separately.
  - ✓ Evaluation and management (E/M) codes for office and/or hospital visits may not be unbundled from the global OB code and billed separately.
    - ☒ Claims for these services will be denied when billed in addition to the global OB code.
- ☒ Physicians and certified nurse practitioners in midwifery (CNMs) may not bill the global OB package if the recipient has been seen for less than 5 visits prior to delivery.
- ☒ Providers *must* bill the global OB code if the recipient is seen five or more times prior to delivery.
- ☒ Providers in group practices may not unbundle the global delivery code when a recipient receives OB services from more than one provider in the group and delivery is performed by a provider in the same group.
- ☒ If a recipient's care is provided by a CNM who refers the recipient to a physician outside the group or practice for consultation, the physician may bill for the consult visit.
- ☒ If the CNM refers the recipient to the physician outside the group or practice for on-going OB care, that physician may bill for the individual visits, plus the delivery unless the requirements related to billing the global OB package are met.



## **PROFESSIONAL AND TECHNICAL SERVICES (CONT.)**

### **Obstetrical services (Cont.)**

- ☒ The CNM who referred the recipient may bill for the visits that occurred prior to referring the patient to the physician outside the group or practice for on-going OB care.
  - ✓ The CNM may not bill for the delivery or global OB code if the delivery is billed by another provider.
- ☒ Billing for other than total care.
  - ✓ A provider may not bill the global OB code or codes for postpartum care if the delivery is the only service provided.
  - ✓ A provider (not part of a group or multiprovider practice as described earlier) who performs a *delivery and subsequent postpartum care only* should consult the CPT code book for the appropriate CPT codes.
  - ✓ A provider billing for *postpartum care only* should use CPT code 59430.
  - ✓ A provider (not part of a group or multiprovider practice as described earlier) billing for *antepartum care only* should use CPT codes 59425 (4 - 6 visits and services) or 59426 (7 or more visits and services).
  - ✓ For 1 - 3 antepartum care visits, a provider should use the appropriate E/M Codes.
- ☒ When billing delivery services for twin births, providers should bill only one global obstetric care code and one code for delivery only with a 51 modifier.
  - ✓ Global obstetric codes include all antepartum and postpartum services and therefore encompass all services rendered to the mother, including instances of multiple gestation.
  - ✓ The global code also includes delivery services for one baby.
  - ✓ Delivery of the second baby should be billed using the appropriate code for delivery only, billed with a 51 modifier.

## PROFESSIONAL AND TECHNICAL SERVICES (CONT.)

### Pathology and laboratory services

- ☒ Diagnostic testing and screening are covered services.
- ☒ Pass-through billing by which the physician pays the laboratory for tests and then bills AHCCCS for the lab services is not allowed.
- ☒ AHCCCS follows Medicare guidelines that specify which codes providers may bill using the professional (26) and/or technical component (TC) modifiers.
  - ✓ The laboratory portion of the claim must be billed with modifier TC.
  - ✓ The professional component of the laboratory service must be billed with modifier 26.
  - ✓ When the procedure code for the test is for the technical component only or the professional component only, the procedure should be billed without a modifier.
  - ✓ Laboratory tests with automated results do not have a professional component, and claims for the professional component should not be billed for those laboratory services.
- ☒ Laboratory services for hospitalized recipients must be included on the UB-92 inpatient claim.
  - ✓ These services may not be unbundled and billed separately from the inpatient claim.
- ☒ In accordance with Medicare guidelines, physicians may bill only a limited number of CPT codes for pathology services performed in a hospital setting.
  - ✓ AHCCCS follows Medicare guidelines and will only pay physicians and other individual practitioners for the medical interpretation of a pathology test performed at a hospital.
  - ✓ AHCCCS does not reimburse physicians for the technical portion of tests performed at hospitals or for any indirect costs, such as supervising the laboratory.
    - ☒ The hospital is reimbursed for the technical component of the test performed in its facility.
    - ☒ The hospital is also responsible for compensating employees that may be supervising the lab.



## **PROFESSIONAL AND TECHNICAL SERVICES (CONT.)**

### **Podiatry services**

- ☒ The following services are covered when provided by a licensed podiatrist and ordered by a licensed physician:
  - ✓ Routine foot care (covered only when the patient has a systemic disease of sufficient severity that performance of such procedure by a non-professional would be hazardous).
  - ✓ Casting for the purpose of constructing or accommodating orthotics.
  - ✓ Bunionectomy is covered only when the bunion is present with:
    - ☒ Overlying skin ulceration, or
    - ☒ Neuroma secondary to bunion (neuroma to be removed at same surgery and documented by pathology report).
- ☒ Limitations and exclusions
  - ✓ Routine foot care provided by a non-professional is not covered.
  - ✓ General diagnoses such as arteriosclerotic heart disease, circulatory problems, vascular disease, or venous insufficiency do not warrant coverage of routine foot care.
  - ✓ Incapacitating injuries or illnesses such as rheumatoid arthritis, CVA (stroke), or fractured hip are not diagnoses for which routine foot care is covered.
  - ✓ Any treatment of a fungal (mycotic) infection is not covered in the absence of:
    - ☒ A systemic condition, or
    - ☒ Clinical evidence of mycosis of the toenail and compelling medical evidence documenting the patient has either a marked limitation of ambulation due to the mycosis which requires active treatment or, in the case of a non-ambulatory patient, a condition that is likely to result in significant medical complications in the absence of such treatment.
  - ✓ Bunionectomy is not covered if the sole indications are pain and difficulty finding appropriate shoes.
  - ✓ Coverage of mycotic nail debridement and/or other routine foot care is limited to:
    - ☒ Routine foot care.
    - ☒ No more than two visits per quarter or eight visits per year (except EPSDT recipients).
    - ☒ No more than one bilateral mycotic nail treatment (up to 10 nails) per 60 days (except EPSDT recipients).

## PROFESSIONAL AND TECHNICAL SERVICES (CONT.)

### Radiology and medical imaging services

- ☒ Diagnostic testing and imaging and MRI are covered services.
- ☒ Positron emission tomography (PET) scans are covered only at PET imaging centers with PET scanners that have been approved by the FDA.
- ☒ No PA is required for medically necessary radiology and medical imaging services.
- ☒ Radiology services provided to hospitalized recipients must be included on the UB-92 claim.
  - ✓ These services may not be unbundled and billed separately from the inpatient claim.
  - ✓ The professional services of a radiologist may be billed separately with a 26 modifier.

### Rehabilitative services

- ☒ AHCCCS covers physical, occupational, speech, audiology, and respiratory therapy services that are:
  - ✓ Ordered by a physician, and
  - ✓ Provided by or under the direct supervision of a licensed therapist.
- ☒ The scope, duration and frequency of each therapeutic modality must be prescribed by the physician.
- ☒ The condition for which physical, occupational, speech, and audiology therapy services are prescribed must be acute, and the patient must have the potential for improvement.
- ☒ Exclusions and limitations
  - ✓ Outpatient speech and occupational therapy services are covered only for EPSDT and ALTCS recipients.
  - ✓ Physical therapy prescribed only as a maintenance regimen is excluded.
  - ✓ No outpatient rehabilitation services are covered for ESP recipients.
- ☒ Respiratory therapists must be billed with the following code:  
S5180 Home health respiratory therapy, initial evaluation



## **PROFESSIONAL AND TECHNICAL SERVICES (CONT.)**

### **Rehabilitative services (Cont.)**

- ☒ Respiratory therapists may not use CPT codes 94010 - 94799.
- ☒ Physicians and hospitals may use CPT codes 94010 - 94799.

### **Residents, interns, and teaching physicians**

- ☒ A hospital may not submit a claim for professional services rendered unsupervised by a resident or intern using the hospital's provider ID, the attending/teaching physician's provider ID, or the chief of staff's provider ID number.
- ☒ Patient services rendered by the attending/teaching physician solely in the capacity of teaching are excluded from reimbursement.
- ☒ The attending/teaching physician may submit a claim for professional services if:
  - ✓ The attending/teaching physician is present for a key portion of the time the service being billed was performed.
    - ☒ For deliveries, the attending/teaching physician must be present for the requisite number of prenatal visits and the delivery in order to bill the global OB code.
    - ☒ If the attending/teaching physician is present only for the delivery, he/she must bill the "delivery only" code. (See obstetrical services, Pages 10-18 – 10-19)
  - ✓ For surgery or complex procedures, the attending/teaching physician is present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure.
  - ✓ For inpatient and outpatient evaluation and management services, the attending/teaching physician is present during the key portion of the visit.
    - ☒ Documentation substantiating the above criteria must be available for audit purposes.
    - ☒ All claims are subject to postpayment review and recovery.

### **Supplies, materials, injectable drugs**

- ☒ AHCCCS does not reimburse providers on a fee-for-service basis for services billed using procedure code 99070 (Supplies and materials, except spectacles, provided by the physician over and above those usually included with the office visit or other services rendered).
- ☒ Providers must use the following codes rather than procedure code 99070:
  - ✓ J Codes for injectable drugs.
  - ✓ HCPCS codes for durable medical equipment and supplies.



## PROFESSIONAL AND TECHNICAL SERVICES (CONT.)

### Surgeon billing

- ☒ Multiple surgical procedures performed on the same recipient on the same day must be billed using modifier 51.
  - ✓ Providers should list the principal procedure on the first line of the CMS 1500 claim form and list the secondary surgeries on subsequent lines with modifier 51.
    - ☒ The principal procedure is reimbursed at 100 percent of the capped fee or billed charges, whichever is less.
    - ☒ Each secondary surgical procedure (up to four) is reimbursed at 50 percent of the capped fee or billed charges, whichever is less.
  - ✓ If a claim is received without modifiers to indicate secondary procedures, the AHCCCS system identifies the first procedure on the claim as the principal procedure.
    - ☒ All other surgical procedures, up to four, are identified as secondary and priced at 50 percent of the capped fee or billed charges, whichever is less.
  - ✓ Claims with more than four secondary surgical procedures are subject to medical review.
- ☒ If multiple surgeons participate in a surgery, the appropriate modifier is necessary to ensure proper payment of claims.
  - 80 Assistant surgeon (reimbursed at 20 percent of the capped fee or billed charges, whichever is less)
  - 62 Two surgeons/different skills
  - 66 Surgical team
  - ✓ If multiple providers bill for the same procedure without modifiers, all but the first claim received will be denied as duplicates.
- ☒ Certain modifiers indicate less than comprehensive surgical care.
  - 54 Surgical care only
  - 55 Post-operative management
  - 56 Pre-operative management



## **PROFESSIONAL AND TECHNICAL SERVICES (CONT.)**

### **Surgeon billing (Cont.)**

- ☒ AHCCCS accepts modifiers 22 - Unusual services or 52 - Reduced services.
  - ✓ These modifiers do not impact reimbursement.
- ☒ Bilateral procedures performed during the same session are identified by using modifier 50 with the CPT code for the second (bilateral) procedure.
- ☒ When a procedure is repeated, use of the appropriate modifier reduces the likelihood that the claim will be denied as a duplicate.
  - 76 Repeat procedure by same physician
  - 77 Repeat procedure by another physician
- ☒ Modifier 78 indicates another related procedure was performed in the operating room during the postoperative period of the initial procedure.
- ☒ Assistant surgeons, including RNFAs and physician assistants, must bill with modifier 80.
  - ✓ When billing multiple surgical procedures, secondary procedures should be billed with modifier 80 and modifier 51.
  - ✓ Assistant surgeons must use codes for delivery only when billing for Cesarean deliveries.

### **Telemedicine**

- ☒ AHCCCS covers medically necessary services provided via telemedicine.
- ☒ Service delivery via telemedicine can be in one of two modes:
  - ✓ *Real time* means the interactive, two-way transfer of information and medical data, which occurs at two sites simultaneously: the hub site and the spoke site.
    - ☒ Hub site means the location of the telemedicine consulting provider, which is considered the place of service.
    - ☒ Spoke site means the location where the recipient is receiving the telemedicine service.
    - ☒ Diagnostic, consultation, and treatment services are delivered through interactive audio, video, and/or data communication.
  - ✓ *Store-and-forward* means transferring medical data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation.

## **PROFESSIONAL AND TECHNICAL SERVICES (CONT.)**

### **Telemedicine (Cont.)**

- ☒ The following medical services are covered, both real time and store-and-forward:
  - ✓ Cardiology
  - ✓ Dermatology
  - ✓ Endocrinology
  - ✓ Hematology/oncology
  - ✓ Home health
  - ✓ Infectious diseases
  - ✓ Neurology
  - ✓ Obstetrics/gynecology
  - ✓ Oncology/radiation
  - ✓ Ophthalmology
  - ✓ Orthopedics
  - ✓ Pain clinic
  - ✓ Pathology
  - ✓ Pediatrics and pediatric subspecialties
  - ✓ Radiology
  - ✓ Rheumatology
  - ✓ Surgery follow-up and consultations
- ☒ Behavioral health services are covered for Title XIX (Medicaid) and Title XXI (KidsCare) recipients.
- ☒ Covered behavioral health services include (real time only):
  - ✓ Diagnostic consultation and evaluation
  - ✓ Psychotropic medication adjustment and monitoring
  - ✓ Individual and family counseling
  - ✓ Case management
- ☒ Non-emergency transportation to and from the spoke site to receive a medically necessary consultation or treatment is covered for Title XIX recipients only.



## **PROFESSIONAL AND TECHNICAL SERVICES (CONT.)**

### **Telemedicine (Cont.)**

☒ Conditions and limitations

- ✓ At the time of service delivery via real time telemedicine, the recipient's PCP, attending physician, or other medical professional employed by the PCP or attending physician who is familiar with the recipient's condition must be present with the recipient.

☒ Other medical professionals include registered nurses; licensed practical nurses; clinical nurse specialists; registered nurse midwives; registered nurse practitioners; physician assistants; physical, occupational, speech, and respiratory therapists; and a trained telepresenter familiar with the recipient's medical condition.

- ✓ For real time behavioral health services, the recipient's physician, case manager, behavioral health professional, or telepresenter must be present with the recipient during the consultation.

- ✓ All services provided via telemedicine must be reasonable, cost effective and medically necessary for the diagnosis or treatment of a recipient's medical or behavioral health condition.

☒ Services must be billed on a CMS 1500 claim form using the "GT" modifier to designate the service being billed as a telemedicine service.

- ✓ Services are billed by the consulting provider.

☒ The following services are the only covered telemedicine services that may be billed for **acute care and long term care recipients**:

93018 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only

93303 Transthoracic echocardiography for congenital cardiac anomalies; complete

93307 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete

93320 Doppler echocardiography; complete

93321 Doppler echocardiography; follow-up or limited study

93325 Doppler echocardiography color flow velocity mapping

99241 Office consultation for a new or established patient, Level 1

99242 Office consultation for a new or established patient, Level 2

## PROFESSIONAL AND TECHNICAL SERVICES (CONT.)

### Telemedicine (Cont.)

- ☒ The following services are the only covered telemedicine services that may be billed for **acute care and long term care recipients** (Cont.):

- 99243 Office consultation for a new or established patient, Level 3
- 99244 Office consultation for a new or established patient, Level 4
- 99245 Office consultation for a new or established patient, Level 5
- 99251 Initial inpatient consultation for a new or established patient, Level 1
- 99252 Initial inpatient consultation for a new or established patient, Level 2
- 99253 Initial inpatient consultation for a new or established patient, Level 3
- 99254 Initial inpatient consultation for a new or established patient, Level 4
- 99255 Initial inpatient consultation for a new or established patient, Level 5
- 99261 Follow-up inpatient consultation for an established patient, Level 1
- 99262 Follow-up inpatient consultation for an established patient, Level 2
- 99271 Confirmatory consultation for a new or established patient, Level 1
- 99272 Confirmatory consultation for a new or established patient, Level 2
- 99273 Confirmatory consultation for a new or established patient, Level 3
- 99274 Confirmatory consultation for a new or established patient, Level 4
- 99275 Confirmatory consultation for a new or established patient, Level 5
- 99354 Prolonged physician service in the office or other outpatient setting; first hour
- 99355 Prolonged physician service in the office or other outpatient; each additional 30 minutes
- 99358 Prolonged E/M service before and/or after direct (face-to-face) patient care; first hour
- 99359 Prolonged E/M service before and/or after direct (face-to-face) patient care; each additional 30 minutes

- ☒ The following services are the only telemedicine services that may be billed for **recipients enrolled with a RBHA or TRBHA**:

- 90801 Psychiatric diagnostic interview examination
- 90804 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, approximately 20 to 30 minutes



## **PROFESSIONAL AND TECHNICAL SERVICES (CONT.)**

### **Telemedicine (Cont.)**

- ☒ The following services are the only telemedicine services that may be billed for **recipients enrolled with a RBHA or TRBHA (Cont.)**:

- 90805 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, approximately 20 to 30 minutes; with medical evaluation and management services
- 90806 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, approximately 45 to 50 minutes
- 90807 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, approximately 45 to 50 minutes; with medical evaluation and management services
- 90808 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, approximately 75 to 80 minutes
- 90809 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, approximately 75 to 80 minutes; with medical evaluation and management services
- 90810 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes
- 90811 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes; with medical evaluation and management services
- 90812 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes
- 90813 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes; with medical evaluation and management services
- 90814 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes
- 90815 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes; with medical evaluation and management services

## PROFESSIONAL AND TECHNICAL SERVICES (CONT.)

### Telemedicine (Cont.)

- ☒ The following services are the only telemedicine services that may be billed for **recipients enrolled with a RBHA or TRBHA** (Cont.):

- 90816 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes
- 90817 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes; with medical evaluation and management services
- 90818 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes
- 90819 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes; with medical evaluation and management services
- 90821 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes
- 90822 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes; with medical evaluation and management services
- 90845 Psychoanalysis
- 90846 Family psychotherapy, without the patient present
- 90847 Family psychotherapy, conjoint psychotherapy, with the patient present, one hour
- 90862 Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
- 90882 Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions
- 90887 Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient



## **PROFESSIONAL AND TECHNICAL SERVICES (CONT.)**

### **Telemedicine (Cont.)**

- ☒ The following services are the only telemedicine services that may be billed for **recipients enrolled with a RBHA or TRBHA** (Cont.):

- 96115 Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, memory, visual spatial abilities, language functions, planning) with interpretation and report, per hour
- 99201 Office or other outpatient visit for the evaluation and management of a new patient, Level 1
- 99202 Office or other outpatient visit for the evaluation and management of a new patient, Level 2
- 99203 Office or other outpatient visit for the evaluation and management of a new patient, Level 3
- 99204 Office or other outpatient visit for the evaluation and management of a new patient, Level 4
- 99205 Office or other outpatient visit for the evaluation and management of a new patient, Level 5
- 99211 Office or other outpatient visit for the evaluation and management of an established patient, Level 1
- 99212 Office or other outpatient visit for the evaluation and management of an established patient, Level 2
- 99213 Office or other outpatient visit for the evaluation and management of an established patient, Level 3
- 99214 Office or other outpatient visit for the evaluation and management of an established patient, Level 4
- 99215 Office or other outpatient visit for the evaluation and management of an established patient, Level 5
- 99242 Office consultation for a new or established patient, Level 2
- 99243 Office consultation for a new or established patient, Level 3
- 99244 Office consultation for a new or established patient, Level 4
- 99245 Office consultation for a new or established patient, Level 5
- 99261 Follow-up inpatient consultation for an established patient, Level 1

## PROFESSIONAL AND TECHNICAL SERVICES (CONT.)

### Telemedicine (Cont.)

- ☒ The following services are the only telemedicine services that may be billed for **recipients enrolled with a RBHA or TRBHA** (Cont.):

- 99262 Follow-up inpatient consultation for an established patient, Level 2
- 99263 Follow-up inpatient consultation for an established patient, Level 3
- 99271 Confirmatory consultation for a new or established patient, Level 1
- 99272 Confirmatory consultation for a new or established patient, Level 2
- 99273 Confirmatory consultation for a new or established patient, Level 3
- 99274 Confirmatory consultation for a new or established patient, Level 4
- 99275 Confirmatory consultation for a new or established patient, Level 5
- 99354 Prolonged physician service in the office or other outpatient setting; first hour
- 99355 Prolonged physician service in the office or other outpatient; each additional 30 minutes
- 99358 Prolonged E/M service before and/or after direct (face-to-face) patient care; first hour
- 99359 Prolonged E/M service before and/or after direct (face-to-face) patient care; each additional 30 minutes
- 99361 Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 30 minutes
- 99362 Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 60 minutes

### Unlisted or unspecified services

- ☒ Procedure codes for unspecified or unlisted procedures (identified by CPT codes ending in “99”) should only be billed in situations where no other code adequately describes the service performed.
- ☒ Providers who bill procedure codes for unspecified or unlisted procedures must describe the service rendered and identify the service in the procedure or operative report.
- ☒ Claims with such procedure codes are subject to Medical Review.



## **PROFESSIONAL AND TECHNICAL SERVICES (CONT.)**

### **Ventilator management**

- ☒ Providers should not bill AHCCCS for any E/M service when submitting claims for ventilator management services.
- ☒ CPT Codes 94656 (Ventilation assist and management, first day) and 94657 (Ventilation assist and management, subsequent days) are global procedure codes.
- ☒ Claims with an E/M code in addition to a ventilator management code are subject to denial during Medical Review.